# Family Emergency Medical Information

VERMONT DEPARTMENT OF HEALTH

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|---|---|
| **Name:** | **Name:** |
| **Date of Birth: ____/____/____/**<br>**Gender: M / F** | **Date of Birth: ____/____/____/**<br>**Gender: M / F** |
| **Hair Color: Eye Color:** | **Hair Color: Eye Color:** |
| **Primary Language:** | **Primary Language:** |
| **Family Emergency Contact**<br>**Name:**<br>**Relationship:**<br>**Primary Phone Number: ( ) -**<br>**Secondary Phone Number: ( ) -** | **Family Emergency Contact**<br>**Name:**<br>**Relationship:**<br>**Primary Phone Number: ( ) -**<br>**Secondary Phone Number: ( ) -** |
| **English Speaking Emergency Contact:**<br>**Name:**<br>**Relationship:**<br>**Primary Phone Number: ( ) -**<br>**Secondary Phone Number: ( ) -** | **English Speaking Emergency Contact:**<br>**Name:**<br>**Relationship:**<br>**Primary Phone Number: ( ) -**<br>**Secondary Phone Number: ( ) -** |
| **Current Medical Conditions:**<br>_____<br>_____<br>_____<br>_____ | **Current Medical Conditions:**<br>_____<br>_____<br>_____<br>_____ |
| **Past Medical Conditions:**<br>_____<br>_____<br>_____ | **Past Medical Conditions:**<br>_____<br>_____<br>_____ |
| **Are you taking any medications?**<br>**Yes / No**<br>**If yes, where are they kept? _____**<br>_____<br>_____ | **Are you taking any medications?**<br>**Yes / No**<br>**If yes, where are they kept? _____**<br>_____<br>_____ |
| **Allergies to Medications:**<br>_____<br>**Other Allergies:**<br>_____ | **Allergies to Medications:**<br>_____<br>**Other Allergies:**<br>_____ |
| **Do you wear (check one or both)**<br>**Glasses ☐ Contact lenses ☐**<br>**Do you wear hearing aides?**<br>**Left ☐ Right ☐** | **Do you wear (check one or both)**<br>**Glasses ☐ Contact lenses ☐**<br>**Do you wear hearing aides?**<br>**Left ☐ Right ☐** |
| **Do you have any personal, religious, or cultural preferences of how you would like your medical care to be provided?**<br>_____<br>_____ | **Do you have any personal, religious, or cultural preferences of how you would like your medical care to be provided?**<br>_____<br>_____ |

Form completed by: _____ Date:_____

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**Instructions for the Family Emergency Medical Information Sheet**

1. Print as many copies of the form as you need for your family.
2. Please complete all areas of the form for each family member.
3. Once the form is completed, place the form in an envelope or plastic sandwich bag.
4. Write “Family Emergency Medical Information” on the envelope or bag.
5. Place the envelope or bag on your family’s refrigerator.
6. Keep copies of the forms in your wallet or purse.
7. During an emergency, give the envelope or bag containing the Family Emergency Medical Information to emergency personnel (for instance, fire department officials, police, and emergency medical providers).
8. Keep the information listed on this form up to date.